

Insured: City Of Chicago Police
Incident Date: 02/26/2012

Date Entered: 02/26/2012

Claimant Information

Employee #: [REDACTED]	SSN: *****6164	Payroll #: 1180
First Name: ROBERT	Middle Name: L	Last Name: HOFER
Date of Birth: [REDACTED]	Gender: Male	Marital Status:
Home Address 1: [REDACTED]	Work Address: 5151 n Milwaukee	Home Phone #: (773)304-8235
Home Address 2: [REDACTED]	Work Address:	Work Phone #:
Home City: Chicago	Work City: Chicago	Cell Phone #:
Home State: IL	Work State: IL	
Home Zip: 60646	Work State: 60630	
Job Title and Code: POLICE OFFICER 1709	Date of Hire: 03/09/1987	
Type of Employee: Full-Time - Regular	# Children <	
Service Time with City/Year: 24	Cost Center: 0573286 : Dept. of Police - Patrol Services	

Additional Employee Information

Grant Funded Project Type:

Project Name/Number:

Star #: 03860
Rank: 9161
Beat/Post #: 1624
Day Off Group: 1
Start Time: 0700
Stop Time: 1600

Assigned to District: 016
Or Unit: 159-
Detailed to Unit:
Or District:

Incident Information

Incident Time: 11:00
Body Part: Multiple Upper Extremities
Nature of Injury: Sprain
Cause of Incident: Fall, Slip, Trip, NOC
Reported Incident: P.O Hofer was executing an emergency take down of a combative subject. During the course of the takedown, P.O. Hofer's rt shoulder, upper arm and elbow were violently jarred upon impact with the floor.
Address Line1: [REDACTED]
Address Line2: [REDACTED]
City: Chicago
State: IL
Zip Code: 60630
Off Duty Activity:

Police Dept R.D. #: [REDACTED]
3rd Party Involvement:

Ambulance #: 40

Fire Department: Yes

Further Investigation

Further Investigation: Further Investigation: CFD Amb 40 and Eng 108 already on scene.
No med attn required at time of the incident.

Initial Treatment:

Date Notified:

Time Notified:

First Person Notification

First Name:
Title:

Last Name:
Phone #:

Vehicle Information

Employee was driving vehicle:

Driver's License #:

Vehicle #:

Plate Number:

Another city employee was driving vehicle:

Driver's Name:

Vehicle #:

Driver's License #:

Plate Number:

Second vehicle involved:

Owner's Name:

Type of Vehicle:

Phone Number:

Plate Number:

Witness

Was There a Witness?:

Name	Address 1	Address 2	City	State	Zip Code	Phone	Employee
			Chicago	IL	60630		Yes
			Chicago	IL	60630		Yes

Lost Time

First Full Day Off Work:

Last Day Paid:

Restricted Duty Description:

Initial Treatment Information

Name	Address 1	Address 2	City	State	Zip Code	Phone
------	-----------	-----------	------	-------	----------	-------

P.O Hofer completed his tour of duty with mild discomfort. Will seek medical attention as needed.

Additional Comments

Comments:

Report Preparation

First Name:

Title:

Email:

Last Name:

Work Phone #:

Reporting Method:

Signature of Witness, Date (DD / Mon / YYYY)

B. I HEREBY CERTIFY THAT I HAVE INVESTIGATED THE DESCRIBED ABOVE AND ATTEST TO THE TRUTH AND ACCURACY OF THE REPORTED INCIDENTS AND REPORTS.

Signature of Person Preparing Report, Star No., Date (DD / Mon / YYYY)

C. I HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE IS CORRECT AND THAT THESE INJURIES WERE SUSTAINED IN THE PERFORMANCE OF DUTY. I HEREBY AGREE THAT IN CONSIDERATION OF THE PAYMENT BY THE CITY OF CHICAGO OF ANY MEDICAL AND/OR HOSPITAL EXPENSES INCURRED AS RESULT OF THE ABOVE INJURIES, I WILL:

1. NOTIFY THE PERSONNEL DIVISION AS TO THE NAME AND ADDRESS OF ANY ATTORNEYS I MAY RETAIN FOR THE PURPOSE OF PROSECUTING A CLAIM ON MY BEHALF BECAUSE OF SAID INJURIES;

2. REIMBURSE THE CITY OF CHICAGO IN FULL FOR ANY SUMS WHICH IT HAS OR MAY EXPEND ON MY BEHALF FOR SAID MEDICAL AND/OR HOSPITAL EXPENSES FROM ANY RECOVERY WHICH I HAVE OR MAY EFFECT FROM THE PERSON OR PARTY WHOM IT IS CLAIMED IS RESPONSIBLE FOR MY INJURIES.

Signature of Injured Member, Date (DD / Mon / YYYY)

D. ☐ INJURED MEMBER IS UNABLE TO SIGN

E. I HAVE RECEIVED THE INJURY ON DUTY REPORT AND RELATED DOCUMENTS AND ATTEST, BASED ON AVAILABLE INFORMATION, THAT IT IS COMPLETE AND SHOULD BE FORWARDED FOR FURTHER INVESTIGATION TO THE COMMITTEE ON FINANCE.

Signature of Unit Commander of Exempt Rank [For the Superintendent] Rank, Unit, Date (DD / MM / YYYY)

F. I HEREBY CERTIFY THAT THE CHARGES MADE FOR SERVICES AS SHOWN ABOVE AND ON THE ATTACHED BILLS ARE REASONABLE

Signature of Medical Administrator, Date (DD / Mon / YYYY)

Approved – Director of Personnel, Date (DD / Mon / YYYY)

Upon completion of the required signatures, please forward a scanned copy via email to iod@chicagopolice.org